



2018

STANDARD OPERATING PROCEDURES (SOPs) FOR COMMUNITY CENTERED MODELS OF HIV TESTING AND ART SERVICE DELIVERY FOR KEY POPULATION

ESWATINI NATIONAL AIDS PROGRAMME

*SOP for Community HIV testing and ART services for key population Adapted from MOH ART Unit_ ver 3.2_ final
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PEPFAR
U.S. President's Emergency Plan for AIDS Relief

 **LINKAGES**
Across the Continuum of HIV
Services for Key Populations



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List of Acronyms

AEs	Adverse events
ART	Antiretroviral
CAG	Community Antiretroviral group
CMIS	Central management information system
CommART	Community Centered ART delivery models
DSD	Differentiated service delivery models
FSWs	Female sex workers
GBV	Gender based violence
Hb	Hemoglobin
HTC	HIV testing and Counselling
ICAP	International for AIDS care treatment Programs
IEC	Information education and counselling
IRIS	Immune reconstitution inflammatory syndrome
KP	Key population
MSM	Men who have sex with men
TG	Transgender people
OIs	Opportunistic infections
ORW	Outreach workers
PEP	Post exposure prophylaxis
PLHIV	People living with HIV
PrEP	Pre-exposure prophylaxis
PSS	Psychosocial support services
SDP	Service delivery point
SNAP	Swaziland National AIDS Program
SOPs	Standard operating procedures
STIs	Sexually transmitted infections
T&S	Test and start
TB	Tuberculosis
WHO	World Health Organization

Contents

Acknowledgements	1
List of Acronyms	2
1.0 Purpose of the SOPs	4
<i>1.2 Scope</i>	4
2.0 Approaches to Community ART service provision	5
<i>Model 1: CommLink</i>	5
<i>Model 2: Expanded CommLink</i>	6
<i>Strategy 1; ART initiation outreach</i>	6
<i>Strategy 2: ART initiation and refill outreach</i>	7
3.0 ART Service Delivery for KPs	10
<i>3.1 Community ART Groups (CAGs)</i>	10
<i>3.2 Treatment Club</i>	11
<i>3.3 ART Fast Track Model</i>	12
4.0 Antiretroviral Drugs Management and Supply Chain	13
5.0 Determining Client Eligibility for community ART initiation	16
<i>5.1 Assessing and Facilitating ART Readiness Tool for Same-day ART</i>	17
<i>5.2 Services to be Provide Before ART initiation</i>	17
<i>5.3 Case Management: Linkage to Facility & Ongoing Patient Support and Monitoring</i>	18
6.0 Monitoring and Evaluation Systems	20
<i>6.1 Management of patient data: Data flow</i>	20
<i>6.2 Indicators to be collected/tracked and for reporting</i>	21
<i>6.3 Retention on ART</i>	23
7.0 Process Control	23
8.0 Annex: Client flow	24
9.0 References	24

1.0 Purpose of the SOPs

This SOP describes the procedures that will be used to support ART services provision for key population (KP) in the Kingdom of Eswatini. This SOP is in-line with the *2018 Swaziland Integrated HIV Management Guidelines*, the *2016 Community-Centred Models of ART Delivery (CommART) Guidelines* and the *2016 SOP for Community-Centred Models of ART Delivery*. HIV-management procedures including ART initiation and follow-up are addressed in the *2018 Swaziland Integrated HIV Management Guidelines* and are not duplicated in this document. In addition, non-ART-specific elements of the original CommLink HTS, linkage and case management program are addressed in existing job aids and the *2016 Expanded CommLink SOP* and will largely not be duplicated. This SOP will address specific procedures on offering and providing community-based ART initiation services for eligible ART-naïve clients seen in KP friendly outreach mobile clinics, implemented under FHI 360 LINKAGES Project since 2017 and subsequently outlines those that are supported through the KP friendly outreach mobile clinics, and those that are linked to longer-term facility-based care and treatment.

1.2 Scope

The SNAP KP Unit and SNAP ART unit, through KP friendly comprehensive mobile clinic services supported by FHI 360, LINKAGES Project will support two ART initiation and ART refills models for KPs including:

1. *Expanded CommLink services* : Early community-based ART initiation services and linkage to a Government health facility, and
2. *Community outreach services* including ART initiation provided at a KP service delivery points (SDP)¹.

All the above-mentioned will be implemented at a national scale, with differentiated services delivery (DSD) progressively rolling out based on priorities within the SNAP KP Unit and MoH ART program. This will be done progressively to determine actual uptake of services by KPs, correct client flow for ART drug refill schedules and to ensure data reporting processes are sufficient, to determine participation rate, ART uptake, linkage to treatment (when applicable),

¹ A SDP is a cluster of hotspots where KPs interact with partners or clients to solicit sex or to meet and socialize.

adverse events (AEs) and/or opportunistic infections (OIs) management and referral practices and retention in care specific for KPs.

Expanded CommLINK and *Community outreach* will start in Sicelwini (Manzini North Inkhundla), Bigbend Mangwaneni (Nkilonko Inkhundla), Ludzeludze, Zulwini and Mahwalala sites and gradually expand to other sites based on MoH guidance. Further, all clients will have access at the outreach mobile clinic to the national KP core minimum package of service (*see Table 1*).

2.0 Approaches to Community ART service provision

Model 1: CommLink

In this model, the outreach mobile clinic team will offer HIV testing and refer reactive clients to a health facility of choice for ART initiation and other care and treatment services. Both reactive and non-reactive clients will be offered the national KP core minimum service package (*see Table 1*). Tracking of client's or linkage and adherence to treatment will be conducted through health facilities staff and enhanced by FHI 360 LINKAGES Project staff, who will use call log tracking systems to link clients to ART supported by trained peer navigators/expert clients.

Procedure

1. Client offered HIV testing at the outreach mobile clinic.
2. Client tests positive.
3. Client escorted by HTS Counselor to the mobile outreach nurse. Client receive counselling and benefits of early ART initiation, importance of long-term retention, adherence to care plan and achieving and sustaining viral suppression.
4. Client receive the national KP core minimum package of services as defined in *Table 1 KP core package* including
5. Linkage to peer navigator to support linkage to the identified health facility of choice for ART initiation.
6. Client is followed up and tracked by the outreach team and health facilities within 14 days up to at least 90 days to confirm linkages to treatment through peer-to-peer tracking and call log systems.

Model 2: Expanded CommLink

The expanded *CommLink Model* comprise of two strategies, namely; Strategy 1 *ART initiation outreach* team and *Strategy 2: ART initiation and refill outreach*.

Strategy 1; ART initiation outreach

This strategy relies on the health facility's ART health care workers extending HIV services to the communities. Implementing partners clinical outreach team will support the health facility in providing outreach for KPs and provide HIV services in selected KP communities where HIV high yield is anticipated. Health facility's ART nurse will mostly be asked to work with implementing partner outreach team within the facility designated working hours. The KP implementing partner outreach team is expected to conduct HIV testing services and refer patient for ART initiation onsite (next gazebo/tent) to a health facility ART team. Those initiated on ART will be assigned health facility's ART number and clients will be retained into care at that health facility.

Procedure

1. Client is offered HIV testing services by implementing partner HTS Counsellor
2. Client test HIV positive
3. HTS Counselor refers both HIV positive and HIV negative clients to health facility ART team onsite for ART initiation and HIV prevention package.
4. Client receive counselling and benefits of early ART, importance of long-term retention adherence to care plan and viral suppression by the health facility team (*see 2018 Integrated HIV Management Guidelines Chapter 5, p.98*).
5. Assess client readiness for ART Initiation by the facility nurse (*see 2018 Integrated HIV Management Guidelines Chapter 5, p.97*).
6. If client is ready for same day ART initiation, retest for verification by the health facility nurse prior to ART initiation.
7. If client is not ready for ART initiation, they are to be linked with peer navigators for further counselling.

8. Baseline lab onsite sample collection and results processed and given to client. These include; CD4, Hb, HbsAg, and pregnancy test by the health facility nurse.
9. A chronic care file will be opened with the health facility ART number assigned to the client by the facility nurse.
10. Offer basic minimum package of care by health facility nurse (*see Table 1*).
11. Document next appointment date on chronic care file, patient green booklet and appointment register.
12. Follow up visits will be done by the facility.
13. Those who decline ART initiation onsite are referred to their facility of choice (*see Model 1*)

Strategy 2: ART initiation and refill outreach

In this strategy, the KP outreach team will offer HIV testing and ART to all reactive clients. All Medicines including anti-retroviral, cotrimoxazole, isoniazid and vitamin complex/B6 , files and ART numbers at each visit will be obtained from health facility within the catchment area in which services will be provided. Those willing to be initiated on ART will be initiated and issued an ART number (issued prior by health facility) and all relevant files will be transferred to the health facility within 5 days of service provision. If mobile outreach occurs outside of health facility operational hours all files will be stored at implementing partner's safe storage M&E lockage filing cabinet awaiting delivery to the health facilities within 5 days. Those clients who decline and choose to initiate ART elsewhere will be linked to the nearest client's preferred health facility using the national referral tool.

Tracking of client's adherence to treatment, or linked to treatment, will be conducted through KP implementing partner enhanced by call log tracking systems to link clients to ART and supported by peer navigators/expert client.

The outreach mobile clinic will provide monthly visits in selected five service delivery points (SDPs) and will team-up with health facilities in the catchment area for the community ART services including storage of client files between the monthly visits.

Fixed visit dates (monthly) will be communicated in advance to all KPs who test both negative and positive for continued comprehensive clinical services including ART refills.

All clients will be provided with comprehensive HIV prevention and care services (*see Table 1*).

Procedure

1. Offer HIV testing to eligible clients at the outreach mobile clinic.
2. Client tests HIV positive.
3. HTS Counselor refers both HIV positive and HIV negative clients to health facility ART team onsite for ART initiation and HIV prevention package.
4. Conduct retesting for verification by the outreach nurse.
5. Outreach nurse will assess client readiness for ART Initiation (*see 2018 Integrated HIV Management Guidelines Chapter 5, p.97*).
6. Client receives counselling and benefits of early ART, importance of long-term retention adherence to care plan and viral suppression by outreach nurse (*see 2018 Integrated HIV Management Guidelines Chapter 5, p.98*).
7. If client is ready for same day ART initiation, then client will be initiated.
8. Baseline lab onsite sample collection and results proceeded and given to client. These will include CD4, Hb, HbsAg, blood glucose and pregnancy test.
9. For those clients with CD4 count greater than 200 cells/mm³, ART initiations will be offered and clients with CD4 count less than 200 cells/mm³ will not initiated at the mobile clinic, but will be immediately referred to a health facility to receive an advanced disease package. These clients will be provided with transport reimbursement within the 5 days turn around.
10. Chronic care file is opened, if client prefers to receive care from a clinic within the health facility geographical catchment area
11. All clients will be offered KP core package of care (*see Table 1*)
12. Client initiated on ART.
13. Document next appointment date on chronic care file, patient green booklet and appointment register
14. ART numbers will be obtained from a health facility /partner collaborative clinic prior to outreach and an ART number is assigned for the client.

15. For those who opt to initiate ART outside MoH geographical catchment area, a National referral form/transfer out to the mother clinic/facility of choice is written. A green booklet is handed to the client and document appointment register.
16. For clients initiated/already on ART, ART refills for KPs will also be provided in this model (*see SOPs for CommART, Eligibility Criteria, Section 7.2 p24 and ART refills. Section 7.4 p25*)
17. Client is informed on the 14 days appointment for a follow-up visit date to the preferred facility but provided the national KP minimum core package
18. Within 5 days, chronic care files to be delivered to the respective health facility.
19. Client to be followed up by the outreach team by using call logs and peer navigation services to confirm linkages to treatment within 7 days and up to 90 days.
20. For KPs already on ART and stable (after 12 months of ART initiation), ART refills will also be provided in this strategy (*see SOPs for CommART, Eligibility Criteria, Section 7.2 p24 and ART refills, Section 7.4 p25*).

3.0 ART Service Delivery for KPs

This patient centered model will be introduced at community. It will focus on three ART differentiated service delivery (DSD) approaches. These include:

- I. Community ART Groups
- II. Treatment Clubs
- III. Fast Track Model at the outreach mobile clinic

3.1 Community ART Groups

This DSD model will rely on pre-existing social networks such as support groups, workmates and families in both rural and urban communities. The implementing partner will facilitate a conducive environment for community ART groups (CAGs) self-formation. CAGs will identify a minimum of 2 up to 6 KP members in the community all from 1 health facility geographical catchment area and supply them with ART for refills on the predetermined schedule in clients 'safe spaces' /SDPs. The CAGs have to choose a representative to facilitate ART refills.

During the delivery of ART refills, if some KP members need medical attention, the CAG representative will link with the nearest client preferred health facilities or reach out to outreach mobile clinic nurses for the appropriate clinical care. This model will allow CAG representatives to access ART medicines from mobile clinic KP HIV positive peers/peer navigators will be encouraged to follow appointment dates for clinical reviews as scheduled (*see CommART SOP, Section 6.4 p18*).

Procedure

1. For KP to enrol they need to meet the commART Eligibility Criteria (*see CommART SOP, Section 6.2, p17*).
2. Implementing partner will facilitate the formation of the CAG by identifying 2 up to 6 peers living with HIV for collection of ART drug refills on monthly rotational basis.
3. Implementing partner will create an environment that allows HIV positive KP peers to self-form a CAG.

4. Ensures all clients are taking ART at the KP outreach mobile clinic. .
5. CAG representative collects ART booklets from peers 24 hours before collection date and communicates with peers prior to getting medicines as guided in the SOP.
6. CAG representative picks up medicines from the outreach mobile clinic for all peers in the group.
7. Nurses at the outreach mobile clinic communicates to CAG representative on group members due for bloods and documents in the client's booklet.
8. On return from the clinic, CAG representative meets peers at their 'safe spaces'/SDPs/hotspots to give each peer medication and any instructions.

Important

Pre-determined dates for mobile clinic visits at designated service delivery points will be communicated in advance to CAG members. CAG representatives will assist by collecting ART on behalf of their members (see above-stated procedure)

3.2 Treatment Club

In this model clients will refill their ART drugs as a group at the same time from the outreach mobile clinic. To maximize efficiency in the delivery of ART care, a group of stable clients will be enrolled in treatment clubs (TCs) where they receive their ART refills, screen for opportunistic infections, provided psychosocial and adherence support at the outreach mobile clinic. TCs will meet four times per year as a club at 3 months intervals and receive their treatment refills within the club. Following every other club visit, i.e., every six months, each member of the club will have a clinical consultation following their meeting. Clients will be enrolled into follow -up treatment clubs by peer navigators in coordination with the nurse.

Procedure

1. Implementing partner will create an environment that allows HIV positive KP peers to self-form a treatment club.

2. TC representatives identify up to 20 peers living with HIV for collection of ART drug refills on quarterly basis.
3. For KP to enrol they need to meet the commART Eligibility Criteria (*see CommART SOP, Section 6.2, p17*).
4. Clients will be assessed for CommART eligibility at the outreach mobile clinic/health facility and confirmed at the facility.
5. Ensures all clients are taking ART at the same health facility and outreach mobile clinic.
6. Pre-determined dates for the TCs meetings will be proposed and agreed by the members themselves. All members will attend the outreach mobile clinic on those agreed dates.

3.3 ART Fast Track Model

In this model, stable ART clients who wish to refill at the outreach mobile clinic individually will be encouraged and given their drugs. The clients will be given a 3-month refill and will go to a facility for every 6 monthly refills coupled with laboratory tests, if necessary. In between the 6-month clinic visits, clients will be fast tracked at the outreach mobile clinic. Through counselling sessions clients will be equipped with adequate skills and empowered to conduct self-assessments and basic self-care management as these are critical to limit loss to follow-up, non-adherence to their ARVs, disease progression and treatment failure.

Procedure

1. Implementing partner will create an environment that allows HIV positive KP individuals to pick up their ART refills at the outreach mobile clinic.
2. Stable ART clients living with HIV will collect ART drug refills individually from the outreach mobile clinic on quarterly basis.
3. For KP to enrol they need to meet the CommART Eligibility Criteria (*see CommART SOP, Section 6.2, p17*).
4. Clients will be assessed for CommART eligibility at the outreach mobile clinic/health facility and confirmed at the facility.

5. The outreach team will introduce the existence of the fast track model to clients who are on ART at the outreach mobile clinic.
6. Ensures all clients are taking ART at the same catchment area health facility and outreach mobile clinic.
6. Pre-determined dates for the TCs meetings will be proposed and agreed determined by the members themselves. All members will attend the outreach mobile clinic on those agreed dates.
7. Following every other ART refill visit at the mobile clinic, i.e., every six months, clients will have a clinical consultation.

4.0 Antiretroviral Drugs Management and Supply Chain

As part of this SOP, ARVs will be obtained demonstration clinics and administered to patients by NATIS trained nurses from the outreach team. To ensure proper management and accountability of these drugs both at facility and community level the following steps must be adhered to:

Procedures

1. Five (5 days) before the outreach mobile clinic visit establish appropriate patient estimates to guide ordering of ART and ensure drugs are available.
2. Requisitions for pharmacy supplies should be made at least a day prior to the outreach mobile clinic visit in order to give the pharmacy time to prepare and package the drugs.
3. Retrieve all files for clients to be reviewed before the specific outreach day.
4. On the outreach day, drugs must be picked up from the facility in the morning before departure to community.
5. Drugs will be prepacked for a patient in case of multiple month refills, in a friendly package labelled with the client's ART number and/or phone number.
6. Conduct pill count the outreach mobile clinic for clients by expert clients/nurse.
7. The chronic care file, ART booklets and encounter form must be duly completed.

8. Data entry for dispensed ART at the mobile clinic should be transferred in the electronic data base within 24 hours.
9. The encounter form/book should be returned to the facility for reconciliation of ARVs taken from the facility with remaining drugs the day after the outreach.

Table 1 Key Population Core Package of Service for HIV Positive and Negative Clients

Type of Service	FSWs	MSM	TG
Core	<ul style="list-style-type: none"> HIV Testing and Counselling Psychosocial support, GBV Screening, post-exposure prophylaxis (PEP) services, and referral to clinical or GBV or legal aid Family planning (education, counselling, screening for pregnancy risk, and provision of short-acting methods and referral for long-acting and permanent methods Promotion of partner/ client HTC Condom use promotion, lubricants condom skills and distribution STI syndromic screening and referral 	<ul style="list-style-type: none"> HIV Testing and Counselling Psychosocial support, GBV Screening, post-exposure prophylaxis (PEP) services, and referral to clinical or GBV or legal aid Promotion of partner/ client HTC Condom use promotion, lubricants condom skills and distribution STI syndromic screening and referral 	<ul style="list-style-type: none"> HIV Testing and Counselling Psychosocial support, GBV Screening, post-exposure prophylaxis (PEP) services, and referral to clinical or GBV or legal aid Promotion of partner/ client HTC Condom use promotion, lubricants condom skills and distribution STI syndromic screening and referral
Expanded Sero-Negative	<ul style="list-style-type: none"> All of Core Quarterly HTC and STI screening Repeated and regular risk-reduction counselling, PrEP 	<ul style="list-style-type: none"> All of Core Quarterly HTC and STI screening Repeated and regular risk-reduction counselling, PrEP 	<ul style="list-style-type: none"> All of Core Quarterly HTC and STI screening Repeated and regular risk-reduction counselling, PrEP
Seropositive Not Yet on Treatment	<ul style="list-style-type: none"> All of core, except HTC Measurable linkage to care and treatment services, referral, outreach workers to mobile clinic to health facilities TB Screening and referral for treatment Enrolment in care, CD4, For FSWs who are pregnant: referral for PMTCT Promotion of community-based HTC to partners & children of sex workers Assessment of STI and other OIs and referral 	<ul style="list-style-type: none"> All of core, except HTC Measurable linkage to care and treatment services, referral, outreach workers to mobile clinic to health facilities TB Screening and referral for treatment Enrolment in care, CD4, Promotion of community-based HTC to partners & children of sex workers Assessment of STI and other OIs and referral 	<ul style="list-style-type: none"> All of core, except HTC Measurable linkage to care and treatment services, referral, outreach workers to mobile clinic to health facilities TB Screening and referral for treatment Enrolment in care, CD4, Promotion of community-based HTC to partners & children of sex workers Assessment of STI and other OIs and referral
Seropositive on ART	<ul style="list-style-type: none"> All of core, except HTC All expanded services for HIV positive not yet on treatment Initiation on ART Care and Treatment Use of PLHIV support groups to access treatment and adherence 	<ul style="list-style-type: none"> All of core, except HTC All expanded services for HIV positive not yet on treatment Initiation on ART Care and Treatment Use of PLHIV support groups to access treatment and adherence 	<ul style="list-style-type: none"> All of core, except HTC All expanded services for HIV positive not yet on treatment Initiation on ART Care and Treatment Use of PLHIV support groups to access treatment and adherence
Swaziland additional SRH Services	Screen tests: for blood glucose, blood pressure, IEC material distribution, anal cancer, pregnancy, breast cancer examination psychosocial support	Screen tests: for blood glucose, blood pressure, IEC material distribution, anal cancer, psychosocial support	Screen tests: for blood glucose, blood pressure, IEC material distribution, anal cancer, psychosocial support

5.0 Determining Client Eligibility for community ART initiation

Clients are eligible for same day ART if they meet all the following criteria:

- HIV-positive
- Are aged 18 years and above
- Retesting for verification has been done and confirms HIV positive status
- Considerations for prior ART:
 - Prior ART history will be determined by first asking the client about prior HIV treatment, using interviewing techniques and probing skills
 - If no ART history is reported, the nurse will call a data clerk at LINKAGES Office to verify that the client is not in the CMIS system, before assigning the patient an ART number the nurse will then verify ART history by searching the client using the national ID or demographics of the client in CMIS using a tablet at the mobile clinic.
- Clients who report defaulting from ART care will not be initiated on ART by the outreach clinic but will be provided all other outreach clinic services and will be supported to restart at their original facility or at a client preferred site and linked to a peer navigator. This will be communicated to the original facility where the client defaulted services by the outreach clinic staff.
- Acknowledge understanding of proper administration and potential side effects of ART, and the importance of ART adherence
- Have no contraindications to same-day ART and as determined through a complete physical and psychosocial assessment, using the psychosocial assessment page in the client's chronic care file (which may be filled in by the psychosocial officer (PSS) Officer prior to ART initiation). Contraindications to same day ART on the mobile unit include:
 - Clients not willing or assessed as not ready to start
 - Signs and symptoms of active diseases or OIs such as meningitis
 - CD4<100 due to need for follow up Crag screening or urine lam testing, and increased risk of IRIS after ART initiation (*see 2018 Integrated HIV Management Guidelines Chapter 5, p.108*).
 - Mental instability, including being under the influence of alcohol or Medicines

- High risk of renal dysfunction (known underlying renal disease, age > 50 years, BMI <18.5, diabetes mellitus, hypertension, nephrotoxic medications)

If clients are not eligible for same-day ART services on the outreach clinic they should be linked to their preferred facility within 7 days through peer-delivered linkage services, including referral and telephone follow up to confirm linkage and retention to care.

If clients are not eligible for same-day ART services, they will still receive the standard outreach clinic services (*see Table 1*).

5.1 Assessing and Facilitating ART Readiness Tool for Same-day ART

Prior to ART initiation, outreach clinic providers should introduce clients to the *CommLink* and *CommART* program, and discuss the benefits of rapid ART initiation, without coercing the client into starting treatment on the day of the HIV test. The following should be discussed with the client:

- Willingness and readiness to initiate ART
- Social support to facilitate adherence to treatment
- Possible barriers to ART retention and potential solutions
- Concurrent medications
- Planned antiretroviral (ARV) drug regimen, dosage and scheduling
- Planned follow-up and monitoring visits and calls
- Possible adverse effects and how to minimize them
- How to recognize symptoms of OIs (and/or IRIS)
- What to do if they develop an adverse event or signs/symptoms of an OI

They will be provided with ongoing adherence counselling and support throughout this process and reassessed for ART readiness after linkage to their referral facility of choice. They will be linked to a peer navigation trained ORW for extended support.

5.2 Services to be Provide Before ART initiation

In addition to eligibility and readiness assessments (which includes HIV retesting for verification, complete history and physical examination), other services to be provided before ART initiation include:

- Integrated HTS, linkage, and baseline clinical services
- Opening of standard HIV chronic-care file (after verification that patient is not already in the CMIS system)
- PIMA CD4 testing with same-day results: this can be used to immediately risk-stratify clients for advanced disease interventions (such as urine TB lam and/or CrAg screening) when clients are linked to referral facilities
- WHO clinical staging
- TB symptom screening
 - If a client has one or more TB symptom, the FHI 360 mobile clinic nurse and ORWs will provide patient navigation services to link this client to a TB facility for a diagnostic workup.
 - Peer navigators will continue to follow the patient for at least 90 days as per the *CommLink* protocol, to ensure that patients without a subsequent TB diagnosis are linked immediately to ART, and that those with a TB diagnosis are initiated on TB treatment and then subsequently on ART, preferably within 2 weeks of TB treatment initiation
- Screening and treatment for sexually transmitted infections (STI)
- Determination of pregnancy status (by self-report or, in some cases, via pregnancy test conducted on the mobile unit): If client reports or is found to be pregnant, they will be linked to PMTCT services to a facility of choice to the client.
- Provision of a 14-day supply of fixed dose combination 1st line ART (TDF+3TC+EFV or TDF+3TC+DTG according to *2018 Integrated HIV Management Guidelines*)
- Provision of a 14-day supply of cotrimoxazole (CTX) preventive therapy.
- Initial, thorough adherence counselling and psychosocial support (to be continued as an ongoing process throughout the case management period, during all client encounters).

5.3 Case Management: Linkage to Facility & Ongoing Patient Support and Monitoring

Individualized, peer-delivered case management will be provided by peer navigators for at least 90 days to help ensure that clients are coping well on ART (job aid, T&S SOP). Case management services include:

- Escort and treatment navigation to, and within, referral HIV-care facility by day 10-14 after ART initiation for a full facility-based appointment, any relevant baseline laboratory tests and ART refill
 - Patients will be offered referral to a facility of their choice (although initial registration of their ART number will be from the outreach clinic (CommART – MOH) as described in *Model 2 Strategy 2*)
- Psychosocial support and informational/motivational counseling
- Follow-up support calls (including 1-2 days after ART initiation) and appointment reminders
- Monitoring for OIs and AEs: Throughout the case management period, but especially in the few days before a client is linked to facility-based care. Peer navigators will be trained to recognize symptoms of OIs (including IRIS) and side effects of ART and will help triage patients and link them for immediate facility-based evaluation as needed.
 - Clients will be educated on these signs and symptoms as well (Section 5.1) and can proactively call their peer navigators for further guidance if these develop, and ORWs will also ask for symptoms of OIs and/or AEs during routine support calls.
 - If a client has signs or symptoms of an OI or develops an adverse drug reaction, the peer navigator will consult with the mobile clinic nurse, or a KP friendly nurse at their preferred facility and facilitate review of the client by a nurse. This can be done by facilitating transport services or escorting the client to the referral facility for further workup and management on the same or next day (including documentation of this outcome in the chronic care file). If an AE is identified, the clinician will also fill out the national adverse event reporting form.

At case closure, FHI 360 mobile service providers will work with the client and identified referral or supporting facility to ensure transfer of all relevant clinical information and continuity of care.

6.0 Monitoring and Evaluation Systems

6.1 Management of patient data: Data flow

The FHI 360 outreach mobile clinic team will work with MoH clinics to manage KP ART initiation files. After determining client eligibility (including verification that they are not already in CMIS) and readiness for ART initiation, the outreach clinic nurse will initiate the following process:

Facilities with CMIS

1. Nurse open chronic care file in the mobile unit and allocates the ART number from MoH clinic
2. Capture data on chronic care file and refill encounter
3. All files are stored at a MoH clinic with files being delivered within five days on the day of initiation by each mobile unit.
4. Files are received at the reception (Peer Navigator/Exert Client) here client's biographic data will be captured to create client's unique identity number or obtain national ID. Clients flip card will be processed and inserted in each client's file to hand to client.
5. Files are then taken to the receptionist/peer navigator to allocate sequential number from the Pre-ART register for every file for filing purposes and capturing into MoH clinic register (-MoH) then taken to the ART nurse.
6. The ART nurse captures the client's information (clinical information) into the ART register using the details from the biographic data
 - Files of clients willing to continue with the clinic are identified and filed according to their sequential numbers (from peer navigator)
 - File of clients willing to continue ART at another facility are transported out from the ART clinic and
 - Referral slips are given to client to take it with them to new sites Files are segregated and transported are made for those files to their respective facilities with copy of referral slip

Refill encounter sheet is sent to MoH facility Facilities with CMIS

- Information on chronic care file is transferred to CMIS
 - Clients going to CMIS sites are transferred through the CMIS to their facilities with ART number (CommART)
7. The ART nurse will ensure that all required documents and data is captured in all the service points and the identity number is available for every client
 8. Client's files and referrals for outgoing clients are arranged according to the mobile units and handed to the nurse for each mobile for transportation to respective facilities.
 9. Clients' files are to reach facilities within 5 days of ART initiation. This enables the receiving facility to undertake any registration and appointment process before the return of the client for the 14-day review.

Facilities without CMIS

In facilities without CMIS data will be collected using ART National Program tools and eventual transfer of these data in the CMIS.

6.2 Indicators to be collected/tracked and for reporting

After HTs and same-day ART initiation, all other services provided, and client outcomes will be documented in the client-specific case files until case closure. Relevant clinical information (such as adverse events or patient transfer) that occur during this time will also be updated in the chronic care file.

Other indicators captured through MoH and program specific forms include:

Expanded KP Clinical Services Provided on the Day of HTS and ART Initiation:

- % of clients that receive HIV repeat testing by a second operator
 - Test result, date, and ID of client nurse administering test
- % of clients that receive CD4 testing
 - CD4 count
- % of clients that receive WHO clinical staging (CARE_NEW)
 - WHO stage
- % of clients that receive TB symptom screening
- % of clients that were identified as TB presumptive that was linked to a facility for further

support

- Confirmed TB cases
- % of clients that receive STI syndromic assessment (STI_SCREEN), % of clients that receive a diagnosis of an STI (STI_DIAGNOSED) and % of clients that are provided treatment for an STI (STI_TREAT).
- Outcome of assessment and if treatment provided
 - % of clients that receive a 14-day supply of CPT
 - % of clients that receive a 14-day supply of ART
 - % of clients who are initiated ART and transferred out for ART follow up successfully
- Outcome of those referred for ART follow up and those that confirm closure of referral.
 - % of clients who are initiated on ART and retained via FHI 360 services at 1 month, 3 months, 6 months and 12 months
 - % of clients who are initiated on ART and retained via non FHI 360 services at 1 month, 3 months, 6 months and 12 months
 - % of clients who are virally suppressed (you might also want to compare viral suppression for clients receiving ART via FHI 360 services vs client receiving on ART via non FHI 360)

Case Management Services Provided Up to 90 Days from Consent

% of clients that receive:

- Psychosocial support and motivational counseling
- Escort and treatment navigation to and within HIV care and treatment facilities
- Follow-up support calls and appointment reminders
- Follow-up counseling sessions on disclosure, partner and family-member testing, and barriers to care
- Support and/or referral for reported clinical symptoms
- Support and/or referral for reported adverse drug events

6.3 Retention on ART

Using routine data sources (facility-based patient charts and/or CMIS), FHI 360 will evaluate retention of clients who initiated same day ART at 6, 12, and annually after initiation

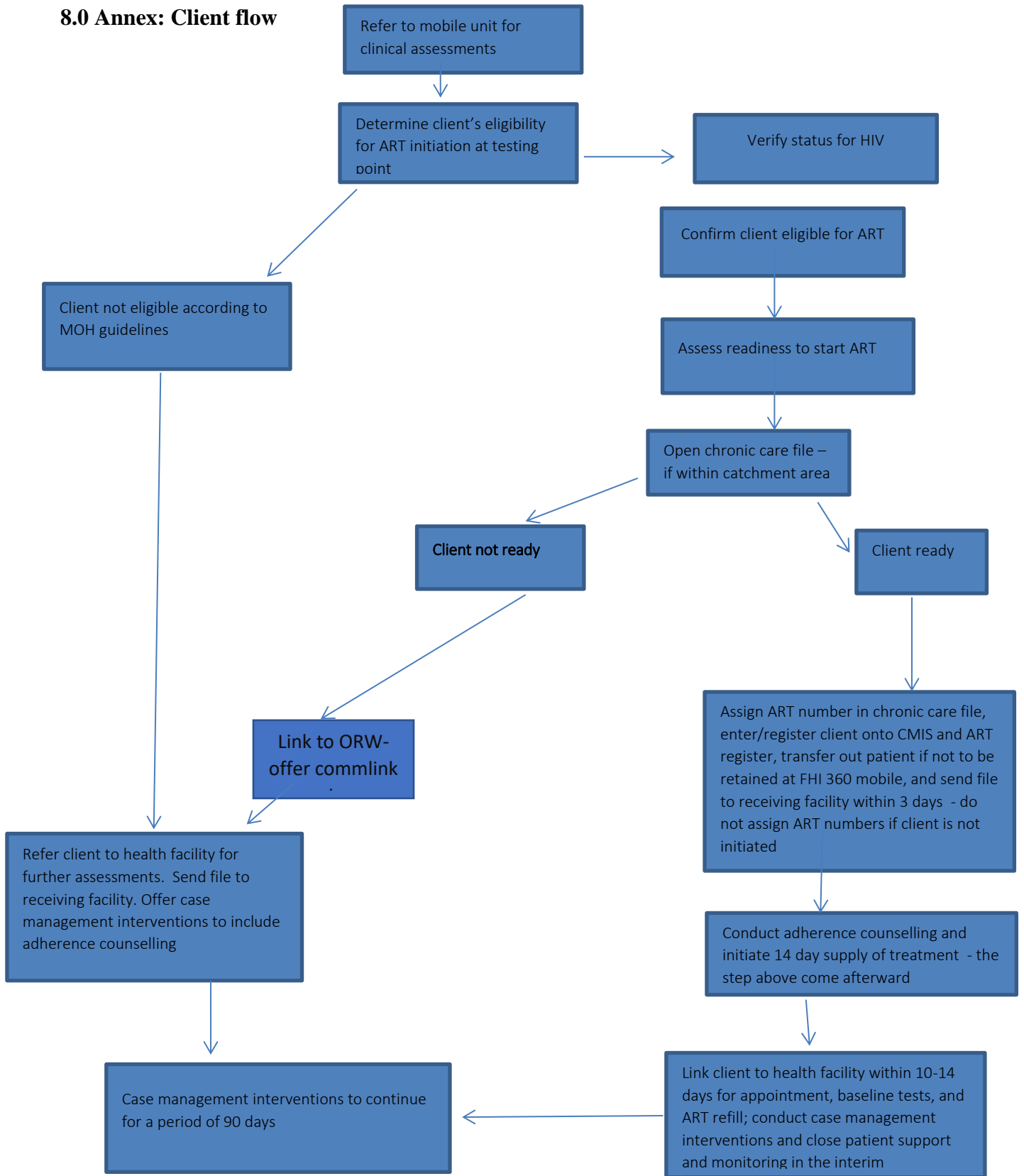
Overall data management procedures will continue per existing approved MOH protocols. FHI 360 will share monthly indicator reports with MoH ART Unit and community stakeholders, and results will be used to determine the success of the pilot

7.0 Process Control

Outreach mobile clinic service providers will be trained on this SOP, take part in relevant national ART trainings (for example introduction of the *2018 HIV Integrated Management Guidelines*), and undergo annual refresher trainings so that they are comfortable with all relevant SOPs and ART initiation procedures. They will also be trained on CMIS use. The Technical Advisor will monitor and supervise all NARTIS trained nurses to ensure that they are offering services in line with national guidelines. This includes direct observation of procedures at least once per quarter, with structured feedback for improvement. In addition, the outreach team personnel meet weekly to discuss challenges and solutions, and clinical partners (ICAP, EGPAF and URC) will also conduct mentoring visits at mobile units to assess compliance with national standards.

The Key Populations Technical Advisor is responsible for ensuring that the document is accurate, current, and meets functional requirements for operationalization in-line with MoH guidance. The Swaziland National AIDS Programme (SNAP) will approve this document before implementation

8.0 Annex: Client flow



9.0 References

- REF 1: CommART Guideline
- REF 2: CommART SOP
- REF 3: HIV Integrated Guidelines, 2018
- REF 4: Patient Linkage, Retention and Follow-Up in HIV Care, 2013
- REF 5: National Referrals and Linkages System Framework, 2014
- REF 6: CommLink Standard Operating Procedures, 2015
- REF 7: SNAP KP Unit Core package of services to key population